

CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS)

ATTENDANT SUPPORT MANAGEMENT PLAN

Client Information					
Client Name:		Medicaid ID #:			
Address:		City:		Zip:	
Phone:		E-mail:			
Authorized Representative's (AR) Contact Information (optional)					
Rep Name:		Relationship to client:			
Address:					
Phone:		City:		Zip:	
E-mail:					
Single Entry Point (SEP) Case Manager Contact Information					
SEP Case Manager Name:		SEP Agency Name:			
Phone:		E-mail:			
Financial Management Services Agency Selection					
FMS Agency (please check one): <input type="checkbox"/> ACES\$ <input type="checkbox"/> Morning Star <input type="checkbox"/> PPL					

<p><u>PART ONE - CARE NEEDS</u></p> <p>Information about me, my supports and my needs:</p>

PART TWO - Needed Attendant Support

1. I (or my Authorized Representative) have the ability to train my attendants to perform all of the activities listed below:

TASKS	SUN	MON	TUES	WED	THUR	FRI	SAT
Homemaker Services: please list time (in minutes) to be completed on task each day.							
Floor Care							
Bathroom Cleaning							
Kitchen Cleaning							
Trash Removal							
Meal Preparation							
Dishwashing							
Bed Making							
Laundry							
Shopping							
Dusting							
Total daily Homemaker hours:							
Personal Care Services: please list time (in minutes) to be completed on task each day.							
Eating							
Respiratory Assistance							
Skin Care Maintenance							
Bladder/bowel care							
Hygiene							
Dressing							
Transfers							
Mobility							
Positioning							
Medical Equipment							
Protective Oversight							
Accompanying							
Bathing							
Medication assistance							
Respiratory Care							

Total daily Personal Care hours:							
TASKS	SUN	MON	TUES	WED	THUR	FRI	SAT
Health Maintenance Services: please list time (in minutes) to be completed on task each day. *Health Maintenance tasks are identified as skilled care tasks that a provider such as a CNA or RN would have traditionally performed outside of CDASS.							
Skin Care							
Nail Care							
Mouth Care							
Dressing							
Feeding							
Prescribed Exercise/ROM:							
Transfers							
Bowel Care							
Bladder Care							
Medical Management							
Respiratory Care							
Medication Assistance							
Bathing							
Total daily Health Maintenance hours:							
Total daily hours:							

The Case Manager is responsible to review the client/authorized representative identified homemaker, personal care and health maintenance services for appropriateness in comparison with the clients CDASS task worksheet. Any services indicated on the ASMP but not on the task worksheet (and vice versa) should be reviewed further by the client/authorized representative and the case manager. Approval should not move forward until service tasks on the task worksheet and ASMP match.

Service frequency and duration identified in this attendant support management plan for each task are an estimate. The frequency and duration of tasks may vary from day to day based on the client service needs.

Are there times during the year that your care needs predictably change and you will most likely need to utilize more or less services? Please share this information

Please inform your case manager if your needs change.

PART THREE - Recruiting and Hiring

The steps I am taking to find and hire attendant(s) are (check all that apply):

Posting Ads:

- | | |
|--|--|
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> College/University |
| <input type="checkbox"/> Library | <input type="checkbox"/> Grocery Store |
| <input type="checkbox"/> On-line web sites (i.e. craigslist) | <input type="checkbox"/> Local Publications |
| <input type="checkbox"/> Medical Facilities | <input type="checkbox"/> Other Bulletin Boards |
| <input type="checkbox"/> Word of Mouth | <input type="checkbox"/> FMS Provider Attendant List |
| <input type="checkbox"/> Recruit Current PCP/CNA/Nurse | <input type="checkbox"/> Recruit Family/Friends |

Other (please specify): _____

PART FOUR – Limitations on Payment to Family

_____ (Initial) I will hire my spouse (through legal marriage or common law) as an attendant. I understand that my spouse is limited to providing extraordinary care as determined by the SEP case manager and my spouse will not be paid for providing more than 40 hours of care in a 7-day period.

OR

_____ (Initial) Not applicable: I will not hire a spouse.

_____ (Initial) I will hire a family member(s) (“family” all persons related to the client through blood, marriage, adoption, or common law) as an attendant(s). I understand that family members and guardians will not be paid for providing more than 40 hours of care in a 7 day period.

OR

_____ (Initial) I will not hire family member(s) and/or guardian(s) as attendant(s).

PART FIVE – Emergency Back Up Planning

2. The steps I plan to take in an emergency and/or during unexpected situations are:
(Please be as specific as possible)

Late / No show Attendant:

Limb or Limb Emergency:

Unexpected illness or flu:

Community Wide Disaster (i.e. flood, blizzard, etc.): What would you do if you had to leave your home? What is your plan if you are unable to leave your home and your attendant is having trouble reaching your home?

Other (optional):



PART SIX – CDASS Monthly Budgeting Worksheet

Monthly Allocation:

Total amount available for attendant support services. Must identify at least two attendants. Rate of pay and total cost must be listed for all primary attendants.

=

1

Attendant	Attendant's Hourly Rate	Your Cost Per Hour*		Hours Per Week		Total Per Week	
			X		=		a.
			X		=		b.
			X		=		c.
			X		=		d.
			X		=		e.
			X		=		f.
Attendant Care Wages Per Week Total Add (a) through (f)							2
Attendant Care Wages Per Month Total Multiply Weekly Total (Box 2) by 4.3 (average weeks in a month)							3
Monthly Amount Remaining. Subtract Box 3 from Box 1. Having a remaining amount each month could assist with unanticipated or emergency care needs.							4

* Refer to the Attendant Wages table in appendix E in the CDASS manual.

PART SEVEN – CDASS Start Date (To be completed by Case Manager)

Preferred CDASS Start Date

Alternate Start Date

PART EIGHT – Signatures

Client / Authorized Representative Signature

Date

Case Manager Signature

Date

Consumer Direct Comments

Reviewer's Signature

Date

FOR SINGLE ENTRY POINT CASE MANAGER APPROVAL - PLEASE DO NOT WRITE IN THIS SPACE

Client receives CDASS through (check one):

Client certification dates:

HCBS-waiver ☐

**CDASS 1915(i)
State Plan** ☐

CDASS Start Date:

End Date:

Case Manager Approval

Date Signed

